RECIPIENT REQUEST FOR SCREENING
for " Candidate Status"
ALZHEIMER'S ASSISTED LIVING WAIVER

*****This is a request to be screened for the Alzheimer's Waiver. Submission of this request form does not guarantee admission into the waiver, nor does it guarantee Medicaid eligibility. This form provides you with the first step to participating in the waiver. The first step is as a candidate. Fill the request form, print, sign, include all required attachments, and fax or mail to the address below.***

RECIPIENT Information:

Name of person to be screened: _____ _____
Last First SS#

Spouse Name: _____

Address (include city, state, zip): _____

County: _____ Phone Number (include area code): (____)_____

Currently resides where: ___ At home ___ in Nursing Facility ___ in Assisted Living Facility

The following questions MUST be answered regarding the recipient for your application to be considered complete:

AGE _____ Date of Birth: _____
Individuals must be 55 years of age or older at time of application and cannot have a diagnosis of Mental Retardation to be eligible for this waiver.

Are you currently Medicaid eligible? Yes ____ No ____
If yes, provide 12-digit Medicaid identification number: _____

Do you have a current diagnosis of Alzheimer's or Alzheimer's related Dementia? Yes ___ No ___
Individuals must have a diagnosis of Alzheimer's or Alzheimer's related Dementia at time of placement.

RESPONSIBLE PARTY Information:

Name: _____ _____
Last First
Address:
City: _____ State: _____ Zip code: _____

Telephone Numbers:
Home: (_____)_____ Work: (____)_____ Cell: (____)_____
These numbers will be used to contact you to information and approval of placement.

***Local Department of Social Service*:**

Name: _____

Address (include city, state, zip):_____

City: _____ State:_____ Zip Code: _____

Case Worker Name: _____(if you have one)

Case Worker Phone Number: _____-_____-_____ Ext: _____

Application Certification:
I hereby certify that the above application and any attachments is a true and accurate representation of _____ current condition and legal status.

_____ _____
Signature and relationship to recipient Date

Please return this completed form to:

DMAS
Facility & Home Based Services Unit
Division of Long Term Care & Quality Assurance
600 East Broad Street, Suite 1300
Richmond, VA 23219
or
Fax to: (804) 786-0206

**NOTE:
You will not receive communication regarding this application unless it is incomplete or you are being called about acceptance as a candidate for the Alzheimer's Assisted Living Waiver.

Once you receive notice of acceptance as a candidate for the waiver you as the applicant will need to obtain the following information as part of your application to an Assisted Living Facility:

1. A completed Uniform Assessment Instrument (UAI) (completed by the local Department of Social Services);
2. A complete physical;
3. A written diagnosis of Alzheimer's *or* Alzheimer's related Dementia, as defined in the as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) by a physician or psychologist;
4. Proof of age; and
5. Any other documentation the facility may need.

FOR SCREENING TEAM USE ONLY

Date Application Received: ___/___/___
Signature of Receiver:_____
Date(s) Contact Made With Applicant:_____
Date Screening Performed: ___/___/___
Service Approved?: □ If Approved, which facility:_____
Service Not Approved?: □ If Not Approved, Reason:_____
Date Applicant Notified: ___/___/___ (Attach copy of letter to this request)